

**Please complete the following medical history form**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_ Sex \_\_\_\_ Referring Doctor \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Skin areas involved: \_\_\_\_\_

How long has the problem been present? \_\_\_\_\_

Was a biopsy done?  No  Yes

Was there any previous treatment?  No  Yes - What \_\_\_\_\_

**Please list all medications:** (Include vitamins, herbs, supplements)

**Allergies:** \_\_\_\_\_

**Past Medical History (Circle all that apply):**

Anxiety

Arthritis

Artificial joints

Asthma

Atrial fibrillation

BPH

Bone marrow transplant

Breast cancer

Colon cancer

COPD

Coronary artery disease

Depression

Diabetes

End state renal disease

GERD

Hearing loss

Hepatitis

Hypertension

HIV/AIDS

Hypercholesterolemia

Hyperthyroidism

Leukemia

Pacemaker

Prostate cancer

Radiation Treatment

Seizures

Stroke

Valve Replacement

Other: \_\_\_\_\_

None: \_\_\_\_\_

Name \_\_\_\_\_

**Past Surgical History (Circle all that apply):**

Appendix removed  
Bladder removed  
Mastectomy (right,left, both)  
Lumpectomy (right,left, both)  
Breast reduction  
Breast implants  
Colectomy (diverticulitis)  
Colectomy (IBD)  
Gallbladder removed  
Coronary artery bypass  
PTCA  
Valve replacement  
Heart transplant  
Joint replacement (which?)

Kidney biopsy  
Kidney removed (right or left)  
Kidney transplant  
Ovaries removed: cysts  
Ovaries removed (ovarian cancer)  
Prostate removed (prostate cancer)  
Prostate biopsy  
TURP  
Skin biopsy  
Skin cancer surgery  
Spleen removed  
Testicles removed (right, left, both)  
Hysterectomy (fibroids)  
Hysterectomy (uterine cancer)

Other: \_\_\_\_\_

None: \_\_\_\_\_

**Skin Disease (Circle all that apply):**

Acne  
Actinic keratosis  
Blistering sunburns  
Dry skin  
Eczema  
Flaky/itchy scalp

Hay fever/allergies  
Poison Ivy  
Precancerous moles  
Psoriasis  
Skin cancer (melanoma, basal cell carcinoma or squamous cell Carcinoma)

Do you wear sunscreen?  No  Yes  SFP \_\_\_\_\_

Do you tan at a tanning salon?  No  Yes

Do you have a family history of melanoma?  No  Yes Who? \_\_\_\_\_

**Social History (Circle all that apply)**

Currently smokes daily  
Currently smokes occasionally  
Has smoked in the past

Drug Use: \_\_\_\_\_

Sexual Partners: one or multiple

Name: \_\_\_\_\_

**Review of Systems (Circle all that apply):**

Pacemaker

Defibrillator

Artificial joint within last 2 years

Artificial heart valve

Need premedication prior to procedures

Allergy to adhesives

Allergy to topical antibiotics

Taking blood thinners

Pregnancy/working on it

Allergy to lidocaine

Rapid heartbeat with epinephrine

Yeast infection with antibiotics

Problems with bleeding

Problems with healing

Problems with scarring (keloid and hypertrophy)

Immunosuppression

Changing mole

Rash

Abdominal Pain

Anxiety

Bloody stools

Bloody urine

Blurred vision

Chest pain

Cough/wheezing

Depression

Fever/chills

Headaches

Joint aches

Muscle weakness

Neck stiffness

Night Sweats

Shortness of breath

Sore throat

Unintentional weight loss